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ABSTRACT

This publication reports on an evaluation of the "HIV/AIDS Education Program" in the New York City public schools during the 1993-94 school year. The program involved the cooperation of many offices within the school system, including the Division of High Schools, the Division of Student Support Services, the six high school superintendencies, the 32 community school districts, District 75 (special education), and school-based staff at every level throughout the New York City public school system. Data were collected through site visits, surveys, and examination of program documents. Chapters of the report focus on the components of the program: training in Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) instruction for high schools teachers; "AIDS 201," HIV/AIDS training for community school district staff; and condom availability. Among the findings reported were: (1) a majority of responding teachers indicated they felt well prepared for HIV/AIDS instruction; (2) there were few requests from parents to excuse their children from attending mandated lessons; (3) the biggest obstacles to the delivery of HIV/AIDS instruction remained the lack of well-trained teachers and the absence of yearly updates of the HIV/AIDS lessons; (4) there is a need for more in-service training of those teachers delivering instruction to special populations; and (5) implementation of the parental opt-out procedure had little impact on condom availability. The report concludes with 15 specific recommendations for training, instruction, and condom availability. (ND)

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OER Report

HIV/AIDS Education Program 1993-94

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EXECUTIVE SUMMARY

The HIV/AIDS Education Program continued to expand and mature during the 1993-94 school year. The program involved the cooperation of many offices within the school system including the Division of High Schools, the Division of Student Support Services, the six high school superintendencies, the 32 community school districts, District 75 (special education), and school-based staff at every level throughout the New York City public school system.

As agreed by the Board of Education of the City of New York and the Centers for Disease Control and Prevention (C.D.C.), the focus of the 1993-94 program was the strengthening of the HIV/AIDS instructional component.

High school instructional trainings were held in the Bronx, Brooklyn, Manhattan, and Queens high school superintendencies and for District 75 staff. The majority of participants were teachers but also included assistant principals, guidance counselors, and other school staff. Most survey respondents rated the training segments as "useful" or "very useful." In addition, more than 90 percent of the respondents affirmed that the trainings helped them feel comfortable delivering HIV/AIDS instruction to students.

The "AIDS 201" trainings for community school district personnel and District 75 staff were designed to update teachers and administrators on the latest information on HIV/AIDS, on New York City and State's instructional guidelines, on the central board's policy regarding confidentiality, and on available resources. Most of the participants were primary school teachers who had not previously attended other HIV/AIDS programs sponsored by the board. The majority of survey respondents rated the training segments "useful," and were overwhelmingly satisfied with the skills of the presenters. Respondents indicated a need for additional age-appropriate training on how to teach HIV/AIDS lessons, as well as age and grade-appropriate instructional materials.

The Technical Assistance (T.A.) Project continued to administer the "Be Active in Self-Education" (BASE) Grant Program. Through funds raised from foundations and private corporations, the BASE Grants support adolescent HIV/AIDS and health-related peer education through mini-grants per student project. However, there appeared to be widely varying degrees of interest among schools and districts in applying for funds. Only half of the responding team leaders reported receiving funds for their high schools.

As for the parent education activities for the 1993-94 school year, the parent/student information forums for high

school students and their parents were very poorly attended and, thus, had little effect on the program. The Comprehensive Health Coordinators (C.H.C.s) and T.A.s continued to favor HIV/AIDS team membership, special P.A. meetings, and parent education workshops as the primary vehicles for educating parents on HIV/AIDS issues.

Over one-half of the responding high school-level instructors taught the six mandated HIV/AIDS lessons in physical education/health classes--a continuing indication that this department was still assuming primary responsibility for the delivery of HIV/AIDS instruction. A positive finding, however, indicated that the majority of the respondents reported that they felt "prepared" or "very prepared" to teach the six lessons; further, according to them, no part of any lesson caused them discomfort during classroom presentation--a major change from previous years.

Very few of the team leaders reported receiving requests from parents to excuse their child from attending mandated lessons. As to the delivery of instruction to special student populations, over one-third of the respondents perceived that certain individuals--such as "over-the-counter" students--were still not receiving all six mandated lessons during the year of their arrival; the same amount also reported that Limited English Proficient (LEP) students were not being taught in their native tongues. Further, two-thirds of the team leaders thought that additional HIV/AIDS instructional materials were needed to serve these special populations.

According to the C.H.C.s and the T.A.s, the biggest obstacles to the delivery of HIV/AIDS instruction at all academic levels remained the lack of well-trained teachers and the absence of yearly updates of the HIV/AIDS lessons. Further, they perceived a need for more in-service training of those teachers delivering instruction to special populations. The C.H.C.s and T.A.s also felt that the participation of C.B.O.s should be increased at all levels--particularly in the areas of staff development, instructional materials development, and social service referrals.

Although the majority of the responding high schools appeared to have adequate condom availability schedules, 25 percent still made condoms available three periods per day or less, or, had no posted schedule at all. More troubling was that 55 percent of the high schools had five or fewer program volunteers--an inadequate number of adults for any but the smallest high schools. When these findings are examined in light of the fact that many team leaders reported an increase in demand for condoms over the previous academic year, it is a cause for concern as to whether the program is adequately staffed.

As to the implementation of the condom availability parental opt-out procedure--a cause for considerable discussion and debate during the fall and winter of 1993-94--its impact on the condom availability component of the high school program appeared to have been negligible. According to team leaders, all parents--including those of recently arriving transfer students--had been notified of the parental option. Only ten percent of the team leaders affirmed that any parents had contacted their respective high schools for clarification of the provision.

RECOMMENDATIONS

Based on the findings from the 1993-94 evaluation of the HIV/AIDS Education Program, the following recommendations are offered:

Training

- Explore the feasibility of continuing to hold district-wide and borough-wide HIV/AIDS instructional trainings for teachers at all grade levels.
- Make a special effort to recruit content-area teachers from subjects other than physical education/health to attend instructional trainings.
- If funding allows, consider increasing the involvement of C.B.O.s in the trainings.
- Urge all districts to encourage their schools to apply for BASE Grant funding and other "peer education" monies, and to "match" these funds whenever possible.
- Continue to provide opportunities for parents of students to participate in HIV/AIDS trainings and workshops.

Instruction

- Foster the delivery of HIV/AIDS instruction in content areas other than physical education/health.
- Continue to actively recruit new teachers at all levels to deliver instruction.
- Explore ways to assist all classroom teachers to discuss HIV/AIDS-related issues during non-mandated lesson periods.
- Whenever possible, provide HIV/AIDS informational updates to instructors throughout the school year.

- Revise the HIV/AIDS mandated lessons at all levels regularly.

- Continue to improve HIV/AIDS instructional materials to make them more culturally sensitive and linguistically accessible.

- Make efforts to ensure that all enrolled students receive the full complement of HIV/AIDS lessons each school year.

Condom Availability

- Explore increasing the number of periods per week that condoms are made available, and ensure that the selected periods are ones that make this service accessible to the greatest number of students.

- Actively recruit more adult staff members to serve as condom availability volunteers in each high school.

- Continue to educate the parents of the high school students about this program and to provide support for them as they make decisions about their child's participation in program activities.

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This report was prepared by the Office of Educational Research, High School Evaluation Unit (OER/H.S.E.U.), of the Board of Education of the City of New York. The evaluation was completed under the direction of Dr. Lori Mei. The study was designed, conducted, and written by Dr. Peggy Lane.

Additional copies of this report are available by writing to:

Dr. Lori Mei
Evaluation Manager
Office of Educational Research
110 Livingston Street, Room 740
Brooklyn, New York 11201

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I. INTRODUCTION

BACKGROUND

HIV/AIDS education was first implemented in the New York City public schools in 1987. In 1989, then Chancellor Richard Green mandated a minimum of six HIV/AIDS lessons per grade in grades 7-12. In February, 1991, the Board of Education (B.O.E.) of the City of New York voted to expand instruction to the elementary school level and, at the high school level only, establish HIV/AIDS education teams, condom availability, student involvement in activities to promote risk-reduction, and parent information sessions. The program currently involves the cooperation of many offices within the school system, including the Division of High Schools, the Division of Student Support Services, the six high school superintendencies, the 32 community school districts (C.S.D.s), District 75 (special education) and school-based staff at every level throughout the New York City public school system.

PROGRAM DESCRIPTION

An internal working group, consisting of staff from all central board offices conducting work related to the Expanded HIV/AIDS Education project, met regularly to share information and to coordinate activities. Several of the offices represented in this group are now integrated in the Division of Student Support Services, which has primary responsibility for the implementation of the program. A project coordinator and six Comprehensive Health Coordinators (C.H.C.s) within the Division of Student Support Services have been assigned to work with the

City's six high school superintendencies, 32 community school districts, and District 75 to support program implementation. Within each superintendency and community school district, the Comprehensive Health Coordinator supports individual schools, coordinates outside resources, and works with outside agencies and regional networks. Within each high school, an HIV/AIDS Education Team, consisting of teachers, school staff, parents, and members of community-based organizations (C.B.O.s), continues to function. Each team is responsible for developing and implementing the program at the school level, with assistance from each high school superintendent's Comprehensive Health Coordinator and from the Office of Comprehensive Health and Substance Abuse Prevention.

The program also receives support from the HIV/AIDS Technical Assistance Project. Funded by a major grant from the Aaron Diamond Foundation, the project supports the high school level HIV/AIDS Education Program by providing resources not otherwise available to the public schools. The Technical Assistance (T.A.) staff brings expertise in the areas of HIV/AIDS education, team building, parent involvement, multilingual and multicultural HIV/AIDS education, staff development and training.

During the 1993-94 school year, the Expanded HIV/AIDS Education Including Condom Availability Program, was organizationally subsumed under the Comprehensive Health Education Program. Partial funding for the board's comprehensive health activities was provided by the Centers for Disease Control

and Prevention (C.D.C.) through a cooperative agreement. As part of this agreement, the focus of the program during the 1993-94 school year became the strengthening of the HIV/AIDS instructional component. The following areas were identified for attention: increasing the skills of teachers of HIV/AIDS lessons at the elementary, junior high, and high school levels; providing ongoing technical assistance to individual schools; continuing to encourage the integration of the curriculum into academic subject classes through training; and the teaching of HIV/AIDS within the context of comprehensive health education.

The following goals, established by the Comprehensive School Health Education Program, guided program activities:

- establish an effective management system in each school led by a qualified individual with school health experience and professional training, to provide leadership and coordination for comprehensive school health education, including the development and implemention of frameworks, guidelines and curricula, designed to prevent important health-risk behaviors and health problems;
- strengthen school health education to prevent specific health-risk behaviors and health problems for which funding is available, such as sexual behaviors that result in HIV infection;
- increase the number and percentage of schools that provide age-appropriate comprehensive health education at each grade level, as well as other interventions and services designed to discourage risk-related behaviors; and
- increase the number and percentage of students at each grade level who receive comprehensive health education, as well as other interventions and services designed to discourage risk-related behaviors.

PROGRAM EVALUATION

The HIV/AIDS Education Program was evaluated by the Office of Educational Research (OER) during the 1993-94 school year. The purpose of this evaluation was to:

- continue to document the functioning of the Expanded HIV/AIDS Education Including Condom Availability Program, in the high schools;
- assess ongoing HIV/AIDS training for community school district and high school staff provided by central board program staff;
- examine the HIV/AIDS instructional program at the high school and junior high school level in terms of identifying different methods of delivery of instruction, determining the extent to which the curriculum is integrated into academic subjects, and identifying additional instructional training and technical assistance needs; and
- explore the impact of parental opt-out provisions regarding condom availability on the Expanded HIV/AIDS Education Including Condom Availability Program.

DATA SOURCES

Evaluators used a variety of techniques to gather information about program implementation and efficacy. These techniques included:

- the review of 1993-94 program documents concerning program goals, objectives, and activities;
- the review of training objectives and agendas for staff trainings;
- site visits to 12 randomly selected high school HIV/AIDS programs to interview HIV/AIDS team leaders;
- mailed surveys to all high school HIV/AIDS team leaders (save the 12 interviewed at their school sites). In all, 73 team leaders (48 percent) completed surveys;

- mailed surveys to a sample of 300 high school instructors in 30 high schools who teach the six mandated HIV/AIDS lessons. A total of 59 instructors (22 percent) returned completed surveys;

- mailed surveys to all community school district health coordinators. Twelve of those individuals (35 percent) returned completed surveys;

- mailed surveys to central board program staff: Comprehensive Health Coordinators (C.H.C.s), Technical Assistants (T.A.s), and Parent Coordinators (P.C.s). Six people (43 percent) returned complete data; and

- self-administered survey data gathered from the evaluations completed by 440 participants at the community school district "AIDS 201" trainings and the high school instructional trainings.

Site Visits

OER consultants conducted one-day site visits during May and June, 1994 to 12 New York City public high schools to interview HIV/AIDS team leaders. These schools were selected to offer diversity on key characteristics. All five boroughs were represented in the sample, with schools ranging in size from less than 500 students to more than 3,500. All four major school types were also represented: academic-comprehensive, vocational-technical, specialized, and alternative. It should be noted, however, that although the schools were chosen to represent the experiences of a broad spectrum of schools in the system, this was not a stratified random sample.

Mailed Surveys

OER consultants designed survey instruments to be mailed to all HIV/AIDS high school and District 75 (special education) team leaders, HIV/AIDS high school-level instructors in 30 selected high schools, the community school district health coordinators,

and the central board program staff involved in offering direct services to this program, the six Comprehensive Health Coordinators and the six Technical Assistants, and the two Parent Coordinators. These instruments were designed to elicit respondents' perceptions of HIV/AIDS training activities, HIV/AIDS instruction, condom availability, HIV/AIDS team activities, student involvement in the program, and parent involvement in the program.

Training Evaluations

In addition to the aforementioned instruments, OER evaluators designed training evaluations to be distributed at the community school district "AIDS 201" trainings and at the instructional trainings for the high schools. These instruments were designed to elicit the perceptions of the school personnel participating in these training events.

SCOPE OF THE REPORT

Chapter II of this report presents an overview of the HIV/AIDS trainings that were held for the community school district staff throughout the year. Chapter III examines the delivery of HIV/AIDS instruction in the high schools. Chapter IV focuses on the condom availability component of the program, and Chapter V presents conclusions and recommendations.

II. TRAININGS

During the 1993-94 school year, the training of school personnel charged with the delivery of HIV/AIDS education services to students continued to be central to program implementation. This chapter presents descriptions of the two major types of trainings, information on the respondents, and the perceptions of those respondents regarding various aspects of the trainings. Also included in this chapter are the responses of the team leaders, instructors, the C.S.D. health coordinators, and the C.H.C.s and T.A.s on issues related to training.

INSTRUCTIONAL TRAININGS

The high school-level instructional trainings for teachers involved in the delivery of the six mandated HIV/AIDS lessons were carried out by the high school superintendencies for teachers and supervising assistant principals of the following subject areas: English/Communication Arts, social studies, the arts, English-as-a-Second Language (E.S.L.), foreign languages, health, and science. These full-day trainings sought to provide teachers and supervising assistant principals with the knowledge and skills necessary to integrate HIV/AIDS education into their respective disciplines. Trainers sought to achieve this goal by:

- providing an understanding of the nature of the HIV disease, and its prevention, transmission, and treatment;
- helping trainees to develop an understanding of critical issues in HIV/AIDS education;

- motivating and supporting instructors in integrating the six mandated lessons into their respective disciplines;
- clarifying the policies of the Board of Education of the City of New York's Expanded HIV/AIDS Education Including Condom Availability Program;
- increasing understanding of HIV/AIDS-related issues; and
- giving participants opportunities to enhance their instructional skills and to design model lessons in the area of HIV/AIDS instruction.

Respondents' Perceptions of Instructional Trainings

Instructional trainings were held in the Bronx, Brooklyn, Manhattan, and Queens high school superintendencies and for District 75 staff. Of the participants in these trainings who completed training surveys (N=142), 86 percent (n=122) identified themselves as teachers, while the remainder served as assistant principals, guidance counselors, and in other assorted positions in the schools. Those identifying their academic discipline included 36 percent (n=49) who were physical education/health instructors, 19 percent (n=25) who taught science, 17 percent (n=23) who were teachers of English, 16 percent (n=22) who were teachers of social studies, 7 percent (n=9) who were E.S.L. teachers, and 3 percent (n=4) who taught foreign languages. (These figures total more than 122 as some respondents checked more than one academic discipline.)

Although the trainings differed slightly, by location, most included such segments as "HIV/AIDS Updates," "Lesson Planning," "Teaching Strategies," and "B.O.E. Policies on HIV/AIDS." When asked to rate the usefulness of these segments, between 53

percent and 100 percent of the respondents rated them as "useful" or "very useful." At only one training--the one held for the Manhattan high schools--were respondents asked to rate the skills of the trainers. Between 69 and 87 percent of those respondents (n=25) rated the trainers as "good" or "excellent." As to the degree to which the trainings prepared the respondents (n=138) to feel comfortable delivering HIV/AIDS instruction to students, between 91 and 100 percent of the respondents affirmed that it had.

"AIDS 201" TRAININGS

Prior to the 1993-94 school year, the Office of Comprehensive Health and Substance Abuse Prevention offered individualized assistance to community school districts and District 75 to support them in meeting the New York State mandate to include a unit of instruction on HIV/AIDS in the Disease-Prevention Component of the Comprehensive Health Education curriculum. With limited staff, it became necessary to run trainings for large groups on a district-wide, rather than school-wide, basis.

The 1993-94 trainings for C.S.D. personnel and District 75 staff were designed to update teachers and administrators on the latest information on HIV/AIDS, on the central board's policy regarding confidentiality regarding individuals' HIV/AIDS status, on New York City and New York State HIV/AIDS instructional guidelines, on how to deal with sensitive issues in the classroom, and on available resources for HIV/AIDS instructors.

The training was not geared to one individual curriculum, nor was it designed to review the actual lessons for which teachers were responsible.

Community School District Superintendents and the Superintendent of District 75 were each given the option of choosing one of four training models that they felt would best deliver instruction for their district. The Comprehensive Health Coordinators assisted the Superintendents by providing information for them to make this decision.

Respondents' Perceptions of AIDS "201" Training

Most of the 440 survey respondents were primary school teachers who had not previously attended other HIV/AIDS training programs sponsored by the Board of Education of the City of New York. Eighty-nine percent identified themselves as teachers, six percent as administrators and five percent as "other" in response to the question about the positions they hold in their schools. Thirty-one percent reported teaching or administering grades K-2, 44 percent reported teaching or administering grades 3-6, and 10 percent reported that they teach or administer grades 7-9. (Fifteen percent checked "other" in response to this question.) Some of the respondents had attended HIV/AIDS training through other programs such as "Growing Healthy"* (17 percent), "Family Living Including Sex Education" (FLISE) in-service courses (12

*"Growing Healthy", is a comprehensive approach to health education for children in kindergarten through sixth grades. "Being Healthy" is a comparable curriculum designed for middle-school students. "FLISE" focuses on family living and sex education.

percent)," Being Healthy" (three percent), and other programs (11 percent). Almost all (93 percent) of the respondents were members of the HIV/AIDS Advisory Committee in their districts.

Respondents were asked to rate the usefulness of various segments of the training program. Seventy-five percent rated both the segment on policy presentation and the segment that provided an update on HIV/AIDS as useful. Sixty-six percent rated the segment Exploring our Personal Relationship to HIV/AIDS as useful, and 64 percent rated the fishbowl discussion (an activity designed to help manage classroom discusions) as useful.

Respondents were overwhelmingly satisfied with the skills of the presenters. In high numbers they rated as "good" or "excellent" the presenter's abilities to present material clearly (90 percent), respond to questions (89 percent), summarize key points (88 percent), and inspire and motivate (80 percent).

Evaluators inquired about how well the training prepared the respondents to present HIV/AIDS material to their students. Seventy-eight percent reported the training raised their comfort level, 64 percent said it increased their knowledge of HIV/AIDS issues, 52 percent reported that it increased their self-confidence, and 49 percent reported that it enhanced their instructional skills. Fifty-three percent reported that the training made them feel more prepared overall.

When asked, in an open-ended question, what they gained from this training that they might share with others in their schools, 61 percent of the 257 people who responded to the question

pointed to the heightened awareness about HIV/AIDS-related issues (e.g., medical, legal, scientific and educational) that they said they gained. Smaller numbers of respondents reported that they could share the access to and awareness of instructional/ informational materials and similar resources (16 percent), and techniques for teaching HIV/AIDS-related issues that they acquired (eight percent). (Fifteen percent gave other responses).

When asked to specify additional training and technical assistance they needed, 165 people responded. One-quarter of those indicated a need for additional age-appropriate training on how to teach HIV/AIDS-related lessons to students. Others pointed to continuing HIV/AIDS-related information updates (16 percent), approved HIV/AIDS-related curricular/lessons plans from their community school districts (10 percent), and additional age-appropriate instructional materials (seven percent). Five percent asked for HIV/AIDS staff development materials to be kept at each school, and 37 percent offered other responses.

When asked if they needed additional materials to help them provide instruction, 169 people responded. Of those, 64 percent specified HIV/AIDS-related age- and grade-appropriate instructional materials, and 17 percent specified community school district-approved HIV/AIDS-related curricula and lesson plans. (Nineteen percent gave other responses).

Forty-one percent (182) of the respondents offered general comments. Of those, 56 percent offered positive feedback on the

training and interesting substantive remarks, 14 percent offered negative feedback on the training (e.g., too rushed, too short, went off in too many directions), and 30 percent made suggestions for future training, and/or discussed the need for a health curriculum cluster in each school.

PEER EDUCATION ACTIVITIES

The Technical Assistance (T.A.) Project continued to administer the "Be Active in Self-Education" (BASE) Grant Program. The BASE Grants Program, initiated in 1991 in New York City public high schools, is an innovative and successful peer education program. Through funds raised from foundations and private corporations, the BASE Grants Program supports adolescent HIV/AIDS and health-related peer education through mini-grants of up to $2,500 per student project. In this way, funds are routed directly to students themselves, who, under the guidance of the program director, must take the lead in every aspect of their projects. The BASE Grant Student Advisory Committee, consisting of six high school students employed part-time, developed the BASE Grants Request for Proposals (R.F.P.s) and marketing posters, reviewed submitted proposals, and established program policy. BASE Grant projects have included community service projects (e.g., working in hospices with patients suffering from AIDS), developing instructional videos (e.g., teaching negotiation skills to help kids "Say 'No' To Sex"), pamphlets listing adolescent health services in the community, student-

designed T-shirts and posters, school calendars, and a quilting project that linked up with the national NAMES quilting project.

In addition to the aforementioned T.A. BASE Grant projects, another program component was developed to address the shortage of trained multilingual high school staff prepared to deliver HIV/AIDS instruction. Bilingual high school students fluent in the dominant languages and cultures of their schools were selected to be HIV/AIDS peer education leaders. They were trained in HIV/AIDS education, group facilitation skills, and workshop design. Upon completion of their training, the peer educators designed, and assisted in the facilitation of HIV/AIDS presentations for E.S.L. and Limited English Proficient (LEP) students in their native languages that were consistent with the values of their cultures. These presentations supplemented the regular classroom-based HIV/AIDS high school instruction.

Respondents' Perceptions of Peer Education Activities

The major respondent groups were each asked a few questions on peer education activities in their schools. According to the C.H.C.s and T.A.s, all of the training of peer educators in the high schools was done through BASE Grant funding. However, they indicated varying levels of interest, by superintendency or community school district, in applying for the available funding to train peer educators. One respondent remarked that "99 percent" of the high schools in his superintendency were engaged in peer education activities, while another responded that "only 10 percent" of the schools in her superintendency were.

Roughly half of the high school HIV/AIDS team leaders (n=73) reported that their schools received BASE Grant funding during the 1993-94 school year. Of those participating schools, approximately 75 percent used their funds for peer education, 60 percent used them to sponsor "AIDS Awareness" days, almost 40 percent held HIV/AIDS fine arts contests, and 35 percent hired community-based organizations (C.B.O.s) for performing arts presentations geared toward adolescents and AIDS.

Seven of the C.S.D. health coordinators (n=12) affirmed that their districts fostered the training of peer educators at the junior high/intermediate school level during 1993-94, and that the districts planned to maintain or expand these efforts next year. However, only one respondent asserted that her district would add its own financial support to the funding supplied through the T.A. Project.

PARENT EDUCATIONAL ACTIVITIES

An addition to the 1993-94 program was a series of parent/student information forums. These forums were conceived as a vehicle for enhancing parental knowledge and promoting parent-student exchange about the goals of the program and about HIV/AIDS issues affecting teens. The forums were held in each New York City borough during the month of February, 1994. Letters were sent to the parents/guardians/custodians of all registered high school students--as well as to the students, themselves--inviting all to attend the forum in their particular borough on a weekday evening from 7:00 p.m. to 9:00 p.m.

As it turned out, the forums were all very poorly attended. It is not known, however, whether this was due to lack of parent/student interest, scheduling conflicts, or the inclement weather of February, 1994.

Respondents' Perceptions of Parent Education Activities

When questioned about HIV/AIDS parent education activities in the community school districts this year, the C.S.D. health coordinators (n=10) responded that parents were mailed HIV/AIDS-related information, that they were invited to special Parent Association (P.A.) meetings, and that some were sent to district-wide HIV/AIDS workshops. A few parents, according to the respondents, also served on their districts' HIV/AIDS Advisory Committees. As to their districts' parent education focus for next year, half of the respondents felt that those efforts would remain the same or be slightly expanded, while the other half was unsure as to what parent education activities were planned for the 1994-95 school year.

At the high school level, the team leaders responded that parents most often learned about HIV/AIDS-related issues during special P.A. meetings and through communications from the superintendents or principals. Thirteen of the team leaders had parent members on their teams, and 15 indicated that their schools had P.A. members and parent volunteers directly involved in HIV/AIDS education activities.

The C.H.C.s and T.A.s (n=6) identified parent training workshops and P.A. meetings as the primary vehicles for parent education at the high school level. All six agreed that the most effective way of educating parents was to involve them as members on the high school HIV/AIDS teams, and also mentioned sending them to school-based or community-based workshops. It was their shared perception, however, that due to lack of staff, not enough parent education was going on at the junior high/intermediate school level in the community school districts.

III. INSTRUCTION

The New York City public schools initially implemented HIV/AIDS education during the 1986-87 school year. Since 1988, the Chancellor's Expanded HIV/AIDS Education Program made six lessons, yearly, of HIV/AIDS education mandatory in every high school at each grade level. As part of the Chancellor's guidelines, instruction was to extend beyond the health education area into as many academic subject areas as possible. During the 1993-94 school year, program administrators continued to extend the high school level HIV/AIDS instruction beyond the health education classes to other academic subject areas. As in the past, the program required that schools implement at least six lessons per grade, per year, of HIV/AIDS instruction.

INSTRUCTORS' RESPONSES

Each of the six mandated HIV/AIDS lessons was taught by between 27 and 34 of the respondents (n=59). Twenty (34 percent) of the respondents reported teaching their lessons during health education classes; 13 (22 percent) in physical education classes; 10 (17 percent) in social studies; five (8 percent), each, in English and in science; two (3 percent) in history; and 10 (17 percent) in other areas such as art education and family group.

When asked about how prepared they felt to teach HIV/AIDS lessons (n=54), 24 (44 percent) of the instructors responded that they felt "very prepared," 17 (31 percent) felt "prepared," 12 (22 percent) felt "somewhat prepared," and one felt "very unprepared." Seventy-four percent of the respondents (n=40)

further indicated that no part of any lesson they taught had made them feel uncomfortable.

As to how they taught their lessons (n=49), 23 (47 percent) of them said they had led their classes in discussion, 11 (22 percent) said they had lectured, eight (16 percent) made use of role-playing, and two (4 percent) assigned outside readings on HIV/AIDS.

Twenty-one (43 percent) instructors also indicated that they had closely followed the B.O.E. curricular guidelines. When asked about particular techniques, resources, etc., that they had found especially effective, 11 (22 percent) of them identified the use of guest speakers (especially People with Aids [P.W.A.s]), eight (16 percent) secured videos (specially those produced for adolescents), seven (14 percent) encouraged student-initiated activities (such as artistic works), four (8 percent) used role-playing, two (4 percent) held panel discussions, and ten others (20 percent) mentioned assorted techniques such as creative writing activities and science experiments.

As to what aspects of the lessons seemed to interest their students most, 15 (31 percent) replied that discussions about "safer sex" practices were the most popular; seven (14 percent) mentioned discussions about HIV positive friends and relatives; six (12 percent), each, identified HIV/AIDS informational updates and general discussions on sexual practices; and 15 (31 percent) listed others such as HIV testing and confidentiality issues.

With respect to improvements in the delivery of HIV/AIDS instruction in the schools, instructors (n=47) thought the delivery of instruction could be improved by more frequent HIV/AIDS updates, by inviting more guest speakers into the schools (especially P.W.A.s), by yearly updates of the six mandated HIV/AIDS lessons, and by the expenditure of additional funds on program supplies and activities. As to what HIV/AIDS instructional materials were needed to teach special populations (e.g., LEP and special education), respondents listed such items as bilingual videos, human anatomical models, and pamphlets and books geared toward these special groups.

A sign that the teaching of HIV/AIDS issues was continuing to spread into the regular academic subject areas was the reaction of the instructors (n=57) to the question, "Did you discuss HIV/AIDS issues in the classroom this year on days when you were not teaching a formal HIV/AIDS lesson?" Sixty-seven percent of them said "Yes."

TEAM LEADERS' RESPONSES

Team leaders were also asked about HIV instruction in their high schools. Respondents (n=71) indicated that in 93 percent of their schools the six mandated lessons were taught at all grade levels during the 1993-94 school year. Thirty-three percent of them rated the instructional delivery, overall, as "excellent," 45 percent as "good," and 19 percent as "fair." Eighty-two percent reported that all six mandated lessons had been integrated into academic subject-area classes.

The team leaders (n=53) were asked to indicate how the six mandated lessons were actually taught, in what disciplines they were taught, and by whom. With respect to the academic backgrounds of the teachers delivering the HIV/AIDS instruction, the responses of 11 (21 percent) team leaders indicated that their schools were still relying heavily on the SPARK (Substance Abuse Prevention Program) staff to teach these lessons in regular academic subject-area courses. Another eight team leaders (15 percent) indicated that their schools were still making extensive use of the physical education and health teachers to teach the six mandated lessons during academic subject-area class periods. Only one team leader indicated that his high school was making heavy use of community-based organizations (C.B.O.s) to teach the six mandated lessons.

As to the high school classes in which the six mandated lessons were actually taught, the most popular choice of academic subject area for the delivery of lessons remained physical education/health, followed by social studies, English, and science, in that order.

With respect to reaching special populations, 37 percent of the team leaders (n=70) reported that there were students in their high schools who had not received HIV/AIDS instruction this year. Twenty-one (30 percent) of the team leaders admitted that no provisions were made in their schools for ensuring that "over-the-counter" students and transfer students received all six lessons during the 1993-94 school year. Twenty (29 percent) team

leaders also stated that Limited English Proficient students in their high schools did not receive the six mandated lessons in their native languages. Only 3 percent of the team leaders, however, perceived that the special education students in their schools were not receiving all six lessons.

The team leaders (n=69) were also asked to approximate how many high school students' parents had requested that their teenager be excused from the mandatory HIV/AIDS education lessons, as provided for under the Chancellor's guidelines. Sixty-two percent of the respondents reported that no students in their high schools were excused from a lesson. Another 28 percent indicated that under 20 students were excused in their high schools, seven percent said that between 20 and 40 students were excused, and three percent reported that over 40 were excused from one of the lessons. (It should be noted that the respondents came from high schools with student populations ranging from under 500 to over 4,000.)

Sixty-three percent of the team leaders affirmed that their high schools were in need of additional instructional materials to better reach special populations. Seventy-one percent of the respondents also listed ways to improve the delivery of instruction to all students, including increased staff development, updated lessons, audiovisual materials for adolescents, and greater involvement of community-based organizations.

COMMUNITY SCHOOL DISTRICT HEALTH COORDINATORS

The community school district health coordinators (N=12) were also asked about their perceptions of the HIV/AIDS instructional programs in their districts. According to the coordinators, most of their schools used the three following curricula: "Being Healthy" "Family Living Including Sex Education (FLISE): AIDS Supplement," and "Comprehensive Health Curriculum: AIDS Supplement." Between 85 and 90 percent of these respondents identified health education and science as the two academic subject areas in which the lessons selected from these curricula were taught.

According to the health coordinators, the chief ways they were overseeing the delivery of HIV/AIDS instruction were by making site visits to the schools, by collecting reports from teachers, and obtaining principals' classroom observations. In order to improve HIV/AIDS instruction for LEP and special education students, these health coordinators held special workshops, ordered supplementary materials, and made use of C.B.O.s. Only half of them, however, reported making efforts to obtain culturally relevant HIV/AIDS instructional materials for the bilingual populations in their district.

As to what they would like their districts to do to improve the quality of HIV instruction (n=8), three suggested increased staff development, two asked for stronger "quality control" measures to be implemented, and the others made suggestions such as increased release time and updated instructional materials.

When asked what the central board could do (n=11), 10 health coordinators suggested the board offer more staff development activities, authorize more funds for the program, and ratify the proposed curriculum for the junior high/intermediate schools.

When asked about the role C.B.O.s played in their schools' HIV/AIDS education program (n=10), five of the health coordinators said that their districts didn't make use of C.B.O.s at all, and five responded that their districts' HIV/AIDS Advisory Councils reviewed all such requests to use them. When used, the C.B.O.s were generally involved in the delivery of classroom instruction, in providing informational materials on the HIV/AIDS epidemic, and in staging performing arts presentations.

COMPREHENSIVE HEALTH COORDINATORS' & TECHNICAL ASSISTANTS' RESPONSES

When the C.H.C.s and the T.A.s (N=6) were questioned about the delivery of instruction at all levels, all six agreed that the biggest obstacle was the lack of trained teachers, with the lack of updated lessons a close second. They believed that the best ways to improve instruction for special populations (e.g., LEP and special education) were to conduct more in-service teacher trainings and to develop more specialized instructional materials geared toward these groups. The C.H.C.s and T.A.s were also in favor of continuing the long-standing participation of C.B.O.s in the HIV/AIDS education program, and identified ways in which these groups could be involved. All six felt that C.B.O.s should have a role in staff development, and half of them thought

that they should be able to provide informational materials and to handle referrals for HIV/AIDS-related services.

IV. CONDOM AVAILABILITY

BACKGROUND

By September of 1993, all of the then-existing New York City public high schools had instituted a condom availability program. Program guidelines required that schools designate at least one area (usually the health resource room) to make condoms and other health resources available to students. The site(s) had to be staffed for a minimum of ten periods per week by at least one male and one female teacher or administrator. As part of the program mandate, these health resource room staff were all to be trained in the program's special Tier II* trainings. Each high school was required to post a schedule of the hours and location of condom availability in an area of the building accessible to all students, and was expected to designate a locked storage space to secure its supply of condoms against damage or tampering.

Implementation of Parental Opt-Out Procedure

An addition to the 1993-94 condom availability component of the program was a parental opt-out provision proposed by the Chancellor and ratified by the central Board of Education. The

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*Training sessions provided by the Board of Education of the City of New York were conducted in three phases, with schools assigned to either Phase I, II, or III, depending on their readiness to implement the program. Each training phase consisted of three tiers: Orientation, a half-day overview of the program; Tier I, a one-day session covering HIV-related policies of New York State and City, and team-building activities; and Tier II, a two-day session to cover topics including adolescent sexual behavior, abstinence, and condom use.

opt-out provision gave high school students' parents/guardians/ custodians the choice of not allowing their non-emancipated children to participate in the condom availability component of the program.

There was considerable discussion and debate in the early part of the 1993-94 school year over the implementation of the opt-out provision. Some current and former members of the central board's HIV/AIDS Advisory Council, along with some of the central board program staff, opposed the introduction of the parental opt-out provision. They maintained that the amendment was contrary to parent opinion, and that it would be expensive and time consuming to implemement--diverting limited resources from an already underfunded program. Others worried that it would have a chilling effect on teen participation, and that student confidentiality could be compromised since "opt-out lists" would be in the possession of each staff volunteer and would be checked prior to making condoms available.

Letters were mailed to every parent/guardian/custodian of a high school child (in the six major languages of the New York City school system: English, Spanish, Haitian Creole, Chinese, Korean, and Russian), advising them of the condom availability component of the program and of their right to file a written request with their child's school that their child not be provided with condoms. Letters were also sent to all of the high school students, advising them of this new policy.

Each high school was directed by the Chancellor to designate a member of its staff to oversee this policy change and to respond to questions from parents, students, and teachers. Principals were also required to continue to provide information on the opt-out procedure to the parents of all newly registered students throughout the 1993-94 school year, and to sign a letter certifying to these notifications and forwarding this letter to their Superintendent. Up-to-date lists of students who had been opted-out of the program were to be in the possession of all program volunteers in each school, and the privacy of those students on the lists was to be protected through the use of student indentification numbers rather than names. Students on the opt-out lists were still permitted to receive counseling and to ask questions of the condom availability volunteers.

TEAM LEADERS' PERCEPTIONS OF CONDOM AVAILABILITY COMPONENT

When asked about the condom availability schedules at their high schools, the team leaders (n=64) described various arrangements in their respective buildings. Almost 45 percent of their schools made condoms available throughout the school day, including before and after school. Another 30 percent of the schools made them available between four and seven periods per day, while 20 percent made them available between one and three periods per day, and the remainder reported that their high schools had no regularly posted schedule for condom availability.

As to the number of sites per school for condom availability (n=72), the majority of the team leaders (65 percent) said their

schools had five or fewer sites available, while another 25 percent had six to ten sites, and the remainder had more than ten sites per school. According to the team leaders (n=64), 55 percent of their schools had five or fewer staff members engaged as volunteers, another 35 percent had between 6 and 10 individuals volunteering, and the remaining schools had more than 10 volunteers.

When asked about the demand for condoms in their schools during the 1993-94 year, 65 percent of the team leaders (n=67) reported a change over last year. Of these 42 individuals, 38 percent saw an increase in demand, 29 percent felt there was a decrease in requests, and the remaining 33 percent did not characterize the change they had identified.

With respect to the new opt-out policy, ten percent of the high school team leaders (n=68) revealed that parents in their schools had contacted the principal's office for clarification of the opt-out letters. As to the number of parents actually requesting that their children be opted-out of the condom availability component of the program, 33 percent of the team leaders said that fewer than 20 parents in their high school had so requested, 40 percent said that between 20 and 49 parents did, 16 percent said between 50 and 79 did, and 11 percent said between 80 and 130. It should be noted that the student population in these participating high schools ranged from fewer than 500 students per school to more than 4,000. Team leaders (n=57) affirmed that when new students entered their schools

during the 1993-94 year, the parents/guardians/custodians of these students were notified of the opt-out policy. Sixty-eight percent said that parents were advised of the policy during in-person registration, 18 percent through mailings to the home, and 14 percent knew parents were notified but did not know how.

V. CONCLUSIONS AND RECOMMENDATIONS

The Office of Educational Research's evaluation of the HIV/AIDS Education Program found continuing expansion and maturation of program components during the 1993-94 school year. In this chapter, some trends are identified--based upon the responses of the sample--and some recommendations for program improvement are offered.

TRAINING

The high school-level instructional trainings--geared toward helping teachers to integrate the six, mandatory HIV/AIDS lessons into their respective academic disciplines--appeared to have been well-received by the majority of the instructors. The largest sub-group of attendees, however, remained the physical education/health teachers--the department that has traditionally assumed the bulk of the responsibility for teaching the six mandated lessons, yearly, although program guidelines specify that the six lessons are to be integrated into as many content areas as possible.

The new "AIDS 201" training for the community school districts attracted mostly primary school teachers. Overall, the respondents were enthusiastic about the training and the trainers, and affirmed that attendance had heightened their awareness of HIV/AIDS and raised their comfort level for teaching HIV/AIDS lessons. Their main requests were for additional age-appropriate training in teaching HIV/AIDS lessons to elementary

school youngsters, and for more age-appropriate instructional materials for this group.

The BASE Grant program continued to play a central role in the funding of peer education activities at the high school and junior high/intermediate school levels. However, there appeared to be widely varying degrees of interest among schools and districts in applying for funds under this program. Only half of the responding team leaders reported receiving funds for their high schools. The C.H.C.s and T.A.s affirmed that some superintendencies and districts were fully participating, while others barely so. Continued support for this program during 1994-95, as well as the willingness of schools and districts to provide matching funds, seemed to be in question.

As for the parent education activities for the 1993-94 school year, the parent/student information forums for high school students and their parents were very poorly attended and, thus, had little effect on the program. The C.H.C.s and T.A.s continued to favor HIV/AIDS team membership, special P.A. meetings, and parent education workshops as the primary vehicles for educating parents on HIV/AIDS issues. Community school district health coordinators indicated that parent education activities were ongoing at the community school district level.

INSTRUCTION

Over one-half of the responding high school-level instructors taught the six mandated HIV/AIDS lessons in physical education/health classes--a continuing indication that this department was still assuming primary responsibility for the delivery of HIV/AIDS instruction. A positive finding, however, indicated that the majority of the respondents reported that they felt "prepared" or "very prepared" to teach the six lessons; further, according to them, no part of any lesson caused them discomfort during classroom presentation--a major change from previous years. Over two-thirds of the high school instructors reported that they also discussed HIV/AIDS-related issues in their classrooms during non-HIV lesson times. With respect to teaching strategies, they reported that the use of guest speakers (especially P.W.A.s), videos produced for adolescents, and the assignment of student projects were particularly effective. As in the past, the instructors continued to request that the central board provide them with more frequent HIV/AIDS updates, yearly revisions of the six mandated lessons, and more opportunities to interact with community-based HIV/AIDS educators.

As to the perceptions of the high school HIV/AIDS team leaders, almost 80 percent of them rated the HIV/AIDS instruction in their schools as "good" or "excellent." Approximately the same percentage affirmed that the teaching of all six mandated lessons had been integrated into academic subject areas. It was

evident, however, that the team leaders were still seeing a disproportionate number of lessons being taught in physical education/health classess--the most popular setting for lesson delivery. In addition, some schools still appeared to be relying upon SPARK counselors, rather than classroom teachers, for lesson delivery. Very few of the team leaders reported receiving requests from parents to excuse their child from attending one of the six mandated lessons. As to the delivery of instruction to special student populations, over one-third of the respondents perceived that certain individuals--such as "over-the-counter" students--were still not receiving all six mandated lessons during the year of their arrival; the same amount also reported that LEP students were not being taught in their native tongues. Further, two-thirds of the team leaders thought that additional HIV/AIDS instructional materials were needed to serve these special populations.

The community school district health coordinators identified the academic areas of physical education/health and science as the two most popular choices for HIV/AIDS lesson delivery in the elementary and junior high/intermediate schools. Half of them reported that their districts made use of C.B.O.s to assist in lesson delivery, to provide HIV/AIDS instructional materials, and to make HIV/AIDS-related performing arts presentations. The health coordinators perceived a continuing need for staff development and the institution of "quality control" procedures to improve instructional delivery. They also noticed a dearth of

culturally sensitive instructional materials for use with particular bilingual populations in their districts.

According to the C.H.C.s and the T.A.s, the biggest obstacles to the delivery of HIV/AIDS instruction at all academic levels remained the lack of well-trained teachers and the absence of yearly updates of the HIV/AIDS lessons. Further, they perceived a need for more in-service training of those teachers delivering instruction to special populations. The C.H.C.s and T.A.s also felt that the participation of C.B.O.s should be increased at all levels--particularly in the areas of staff development, instructional materials development, and social service referrals.

CONDOM AVAILABILITY

Although the majority of the responding high schools appeared to have adequate condom availability schedules, 25 percent still made condoms available three periods per day or less, or, had no posted schedule at all. More troubling was that 55 percent of the high schools had five or fewer program volunteers--an inadequate number of adults for any but the smallest high schools. When these findings are examined in light of the fact that many team leaders reported an increase in demand for condoms over the previous academic year, it is a cause for concern as to whether the program is adequately staffed.

As to the implementation of the condom availability parental opt-out procedure--a cause for considerable discussion and debate during the fall and winter of 1993-94--its impact on the condom

availability component of the high school program appeared to have been negligible. According to team leaders, all parents--including those of recently arriving transfer students--had been notified of the parental option. Only ten percent of the team leaders affirmed that any parents had contacted their respective high schools for clarification of the provision. Further, although team leader responses were not matched by school size, their perceptions of the number of families electing the parental opt-out procedure at their schools was quite low.

RECOMMENDATIONS

Based on the findings from the 1993-94 evaluation of the HIV/AIDS Education Program, the following recommendations are made:

Training

- Explore the feasibility of continuing to hold district-wide and borough-wide HIV/AIDS instructional trainings for teachers at all grade levels.
- Make a special effort to recruit content-area teachers from subjects other than physical education/health to attend instructional trainings.
- Consider increasing the involvement of C.B.O.s in the trainings.
- Urge all districts to encourage their schools to apply for BASE Grant funding and other "peer education" monies, and to "match" these funds whenever possible.
- Continue to provide opportunities for parents of students to participate in HIV/AIDS trainings and workshops.

Instruction

- Foster the delivery of HIV/AIDS instruction in content areas other than physical education/health.
- Continue to actively recruit new teachers at all levels to deliver instruction.
- Explore ways to assist all classroom teachers to discuss HIV/AIDS-related issues during non-mandated lesson periods.
- Whenever possible, provide HIV/AIDS informational updates to instructors throughout the school year.
- Revise the HIV/AIDS mandated lessons at all levels regularly.
- Continue to improve HIV/AIDS instructional materials to make them more culturally sensitive and linguistically accessible.
- Make efforts to ensure that all enrolled students receive the full complement of HIV/AIDS lessons each school year.

Condom Availability

- Explore increasing the number of periods per week that condoms are made available, and ensure that the selected periods are ones that make this service accessible to the greatest number of students.
- Actively recruit more adult staff members to serve as condom availability volunteers in each high school.
- Continue to educate the parents of the high school students about this program and to provide support for them as they make decisions about their child's participation in program activities.